ALFs and PACE:
A Synergy of Missions

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Keeping pace with the growing needs of elderly Americans presents an ongoing challenge for the health care industry. Whereas nursing facilities were once the only option for aging individuals with varying levels of care needs, assisted living has become a more popular choice in recent years. However, as residents in this setting continue to age and require increasingly complex services, the specter of nursing home placement again becomes a reality. ALFs then must decide whether they can continue to support these residents or inform that they must move to another setting.

One promising solution to this problem is the Program for All-inclusive Care for the Elderly (PACE), an initiative that shares AL's commitment to enabling seniors to age safely in place. PACE and AL partnerships to date set an example of what can be accomplished when health care entities join forces with the well-being of the elderly as a key goal.

What Is PACE?

PACE is modeled after On Lok Senior Health Services in San Francisco. In the mid 1970s, the Chinatown community was faced with a shortage of nursing home beds for its elderly. Many of these individuals were monolingual Chinese, so they had special social needs as well as care requirements common in aged populations. The community board of Chinatown hired a consultant who developed the On Lok Senior Health Services, which eventually became the national PACE program. Today, there are approximately 40 PACE sites throughout the United States.

This program operates as a managed care organization and receives monthly capitated payments for participants' care.* The amounts generally come from Medicare and Medicaid, although those participants who are financially ineligible for Medicaid can pay that amount privately, even though they will still need to pass the Medicaid functional eligibility screen. The amounts paid by Medicare and Medicaid are based on the costs to care for a similar population of clients in the community.

Enrollment in PACE is limited to those individuals who are over age 55 and certified by their state as being functionally in needs of a nursing facility level of care. That screening certification for nursing home eligibility varies from state to state and usually involves deficits in several activities of daily living (ADLs), medication supervision, and/or supervision for safety because of dementia.

**Patients enrolled in PACE are called participants as opposed to clients, residents, or patients, as they "participate" in their care.*

PACE's success derives from its basic principles of operation. First, the integrated financing makes PACE fiscally responsible for all of participants' care. There is no cost shifting as the money is pooled; and there is no Medicare or Medicaid label attached to the money. PACE can use the monies for any care that the participant may need to remain in the community. These services may not normally be covered by Medicare or Medicaid, such as maintenance rehabilitation therapies, if these service will allow the participant to remain in the community. PACE always looks for the most cost-effective service to maintain the participant's community residence and has the incentive and the resources to move participants out of nursing homes whenever possible.

Secondly, the services are integrated through the use of interdisciplinary teams. The participant is assigned to one Adult Day Health Center (ADHC) where an interdisciplinary team is located. The Center contains a medical clinic, day center, and rehabilitation area. The ADHC team usually consists of a physician, nurse practitioner, nurses (RNs and LPNs), physical and occupational therapists, homecare nurses, social workers, a driver, dieticians, and a recreational coordinator. This team formulates, monitors, and adjusts a specific care plan for each participant based on his or her individual needs as determined by each member's assessments. The services then are allocated as determined by that plan of care.

Finally, these same team members become responsible for care delivery. During a daily team meeting, they report any significant changes involving any participants so that their plan of care can be adjusted accordingly.

Utilized together, these elements set PACE apart and have established it as the pre-eminent health care system for the frail elderly.

PACE and ALFs

ALFs are an optional service under the PACE regulations, although some states do not allow PACE organizations to contract with any ALFs. However, in states where these relationships are allowed, PACE contracts with the ALFs and pays some of the cost while the participant may pay the other part. For the ALF, PACE helps to enable aging in place and allow for more ready access to medical care.

When ALFs have a PACE relationship, residents who are PACE participants have ready access to geriatricians and geriatric nurse practitioners. PACE offers a system where there is coordinated care and the presence of a physician who clearly is in charge; and the program provides transportation to outside medical appointments.

PACE's success derives from its basic principles of operation: integrated financing, integrated services, and team-oriented care.

At the same time, PACE champions a strong primary care leadership model where the day center physician and that team assume responsibility and authority. The PACE clinic organizes all consults, and the PACE primary care team reviews all recommendations from consulting physicians. The primary care physician looks closely at these recommendations in context of the overall plan of care, the participant's goals, and other confounding medical, functional, and social issues.

The physician also will discuss these recommendations with the participant and family members or other caregivers. After everyone involved reviews and discusses the recommendations, these are approved, modified, or rejected; and the new orders are communicated to the ALF.

In addition, the program focuses on the functional deficits of the participants, knowing that these impairments often result in nursing home placement. PACE is not hampered by Medicare regulations regarding the provision of physical or occupational therapy, home health, or social work therapies. Each discipline makes decisions about service frequency based on needs and expected outcomes.

Besides covered services such as physician visits, PACE offers residents and their facilities other, less obvious benefits. For example, attendance at the ADHC on a scheduled basis may present frail residents with an opportunity to engage in social and recreational activities that are no longer available to them at the ALF because of their functional or cognitive impairments. Elsewhere, PACE often will provide additional home health services so that residents can remain in their ALF apartments or units. Finally, if participants reach a stage where active treatment and improvement are not an option, PACE can work with the ALF to ensure that these resident have appropriate end-of-life care.

PACE in Action: One Site's Story

For PACE, ALFs offer yet another alternative for continued community residence. Total Longterm Care (TLC), a PACE site in Denver, CO, contracts with a wide variety of ALFs—from the small family-based-units of 2-5 residents to facilities with 120 residents that have as many as 60 residents enrolled in TLC. The site currently has about 30% of its 1,015 enrollees living in ALFs.

(continued on page 41)

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(continued from page 14)

The relationship between TLC and its ALF partners is very synergistic and interactive. TLC often assesses participants and determines that they can no longer reside in an independent setting. At this time, the site asks ALFs to evaluate these individuals to determine whether the facilities can meet participant needs in partnership with TLC. Other times, the ALF sees that their participant needs more assistance than it can provide—especially regarding the coordination of medical care—and refers the resident to TLC. Some ALFs have used this relationship as a marketing strategy.

PACE offers a practical and innovative option for senior care.

The ALF plays a critical role in the success that TLC has achieved in terms of meeting its goal of enabling participants to maintain community residence. TLC understands the challenges, needs, and limitations of the assisted living setting, so the site makes it a priority to communicate plans of care and treatment changes quickly and clearly to the facility. TLC team members know that most ALFs have limited, if any, nursing personnel and have their own regulations with which they need to comply. Therefore, the site works daily to balance its actions with the facility's needs and concerns—with residents' best interest always as a priority

Communication between TLC and the ALFs also is essential. The site facilitates open and prompt communication so that its team can work with ALF staff to agree on the optimal care of participants when an urgent medical problems arise. This care could include an emergency room visit, a home health nursing visit, or transportation to the ADHC for urgent evaluation by the center's physician.

As with all relationships, periodic problems happen. TLC has found that the best resolution always arises from close and constant contact between the PACE center and the ALF manager. Most issues involve communication problems. For example, the two sometimes will arrive at different assessments regarding resident needs, ie, one program believes that ALF is an appropriate care setting for a specific individual and the other does not.

Such situations require a meeting to review each side's assessment to ensure that all the relevant information is shared. Most commonly, a face-to-face meeting and detailed review of the individual's specific medical information results in a decision. However, there are times when a consensus cannot be reached. When this happens, the participant may have to choose between remaining with TLC or staying in the ALF; or TLC would have to find a different ALF, provide more services to that ALF, or place the participant in a nursing home.

PACE and ALFs: Happily Ever After?

While PACE is not a panacea, it offers a practical and innovative option for senior care. At the same time, PACE and ALFs increasingly are enjoying partnerships that enable residents to age in place and continue to call the facility home as their frailty increases and they require more services and higher levels of care. ALC

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See www.npaonline.org for a list of existing PACE sites and PACE sites in the developing phase. More details on TLC can be found at www.totallongtermcare.org.

Alert: Keeping Mosquito-Transmitted Diseases from Bugging AL Residents

(continued from page 29)

outside activities when spraying is expected. It is important to ensure that all outside areas are sprayed and that extra efforts are taken for special outdoor events. Of course, public safety needs to be addressed and all protective measures implemented to shield residents and staff from exposure to sprays and pesticides.

Triumvirate of Management Responsibilities

Facility management responsibilities are three fold. First, a manager should be in contact with the Public Health Department on a regular basis. Weekly and monthly reports that can be mailed or accessed online identify communicable diseases in your area (see the *CDC: Morbidity and Mortality Weekly Report* at http://www.cdc.gov/mmwr or your state health department's morbidity reports). Additionally, there are a number of publications that can help educate staff about prevention mechanisms or particular diseases.

Second, management must address residents' health status. This calls for staff education that ensures that everyone knows what signs and symptoms to watch for that may suggest a resident has been bitten by a mosquito and/or has a mosquito-transmitted illness. It also calls for communication with residents and family members about these illnesses and how to prevent them.

The third responsibility is to ALF staff. Inservice education programs can address prevention techniques, how to monitor resident behavior, and maintaining personal health. Professional staff should request information about resident behavior to ensure that appropriate monitoring is happening and that non-licensed staff are reporting what they have observed. In addition to inservice programs, it is important

(continued on page 42)